STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING _____ B. WING _____	R-C 03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NEWBURGH	5233 ROSEBUD LN NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the investigation of complaint number IN00144440 completed on 2/21/2014.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint Numbers IN00140789 and IN00139682 completed on 1/9/2014.

Complaint number:
IN00144440 - Corrected

Survey dates: March 17 and 18, 2014.

Facility number :011049
Provider Number: 155670
AIM number: 200258520

Survey Team:
Denise Schwandner RN TC
Diane Hancock RN
Diana Perry RN
Anna Villian RN
Barb Fowler RN

Census bed type :
SNF/NF 85
Total 85

Census Payor Type:
Medicaid 60
Medicare 17
Other 8
Total 85

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING _____ B. WING _____	R-C 03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NEWBURGH	**5233 ROSEBUD LN NEWBURGH, IN 47630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Signature Healthcare of Newburgh was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00144440. Quality review completed on March 18, 2014, by Jodi Meyer, RN	{F 000}		